JEFFERSON PILOT FINANCIAL

Jefferson Pilot Financial Insurance Company
P.O. Box 2616, Omaha NE 68103-2616
(800) 423-2765 fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: **TWNDAVIE**	GROUP POLICY #: 000010109698 Life & AD&D & SLI, 000010109700 WI, 000010109699 LTD, 000400001000-09087 Vol Life & Vol Child Life	Billing Division or Location: 768563, 788004, 788005, 788006

Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) Town of Davie			County	Employer ZIP	State
Employee Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Street Address		City	State	Zip	

Gender: ☐Male ☐Female	Marital Status: ☐Married ☐Single	Home Phone ( )	Occupation	Average Hours Worked Per Week:

Completed By Employer

Earnings: $_____ ☐ Hourly ☐Monthly ☐ Weekly ☐ Yearly	Date of Full-Time Employment: Rehire Date:	

Product Selection (Complete for ALL Enrollments)

Basic Coverage NOTE: Please mark the box or boxes for each coverage you are applying for.
All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Class	Effective Date	Type of Coverage			Amount of Coverage	Total Premium
		Basic Group Life/AD&D	☒**Yes**	☐**No**	**$**	Employer Paid
		Dependent Life	☐**Yes**	☐**No**	**$**	**$**
		Short Term Disability	☒**Yes**	☐**No**	**$**	Employer Paid
		Long Term Disability	☒**Yes**	☐**No**	**$**	Employer Paid

Voluntary Coverage NOTE: Please mark the box or boxes for each coverage you are applying for.
All coverage amounts are subject to the limitations and exclusions as stated in the policy.

TYPE OF COVERAGE			AMOUNT OF COVERAGE	TOTAL PREMIUM
Voluntary Employee Life Insurance	☐**Yes**	☐**No**	$	$
Voluntary Dependent Child Benefit	☐**Yes**	☐**No**	☐ **$10,000**	$

Beneficiary Information (Complete ONLY for Life or AD&D Enrollments)

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

Request for Coverages
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:
❑ **REQUEST COVERAGE for which I am or may become eligible under the group policies issued by Jefferson Pilot Financial Insurance Company.** I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.
❑ **NOT ENROLL myself in the Program.** I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.
❑ **NOT ENROLL my dependents in the Program.** I understand that if I apply for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

NOTICE: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM OR APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

The insurance requested on this enrollment form will not be effective until approved by the Home Office of Jefferson Pilot Financial Insurance Company, and the initial premium is paid to Jefferson Pilot Financial Insurance Company. A delayed effective date will apply if the employee is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name:_____ Employee Signature:_____ Date:_____